

Health & Welfare  
 S. Public Health Service  
 5. 300  
 v. 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 securing the medical certificate in no specific manner required by 193.140 MoRS 1949.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

42900  
 STATE FILE NUMBER  
 Registror's No. 2747

FILED NOV 22 1957

Registration District No. B.17 Primary Registration District No. 541

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MEHARRILLE</u>		4 000 Yes <input type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis Co Hosp D.O.A</u>			Length of stay in 1b <u>D.O.A</u>	d. STREET ADDRESS (If outside, give location) <u>Rt 8. Box 722</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dorothea</u> Middle <u>EMILIE</u> Last <u>Tyra</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN-30-1914</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>CUBA MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH JEDLICKA</u>				14. MOTHER'S MAIDEN NAME <u>MARIE MASHEK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR WILLIAM TYRA</u>		Address <u>Rt 8-Box 722 MEHARRILLE MO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	DUE TO (c) _____	345X				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>6-25-57</u> to <u>7-9-57</u> and last saw her <sup>her</sup> <sub>been</sub> alive on <u>11-2-57</u> Death occurred at <u>3:00</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <u>Robert W. Blasko</u>				22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo</u>		22c. DATE SIGNED <u>11-7-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>NOV-5-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION SEM.</u>		23d. LOCATION (City, town, or county) (State) <u>CLAYTON MO.</u>		
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME, MEHARRILLE MO</u>			25. DATE RECD. BY LOCAL REG. <u>11-5-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert S. Danko</u>		

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 419

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.